REPORT FORM

KANSAS REFUGEE HEALTH ASSESSMENT

REQUEST FOR PAYMENT:

Refugee Health Coordinator
KDHE
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

Name:_____ **"A" Number:**_____

Address:_____

Sex:___ **DOB**_____**Arrival Date**_____ Country of Origin_____ USPHS Class____ **KS County:**_____

Language:_____ **Assessment**_____ **Varicella Vaccine #1**_____ #2_____
Date Completed: Date Date

Health Assessment
Status: Incomplete ❑ Private Health Care ❑ Moved ❑ Refused ❑ Lost to Follow-up ❑ Medicaid # _____

√_____ _____
Provider Signature Date

HEALTH ASSESSMENT

HEALTH HISTORY: (OTHER SIDE) Health History Complete: **YES ❑ NO ❑**

LABORATORY AND SCREENING

TEST	DATE	FINDINGS	Referral	Referral Date
TB SKIN TEST			YES ❑ NO ❑	
HGB/HCT			YES ❑ NO ❑	
URINALYSIS			YES ❑ NO ❑	
OVA/PARASITES			YES ❑ NO ❑	
HEP B (HBsAg)			YES ❑ NO ❑	
HEARING			YES ❑ NO ❑	
VISION			YES ❑ NO ❑	

PHYSICAL EXAMINATION: (OTHER SIDE)

Physical Exam Complete: **YES ❑ NO ❑ or NA ❑**

Weight:_____ ***H***eight:_____ ***BP***_____

Referred? **YES ❑ NO ❑**

IMMUNIZATIONS:

IMMUNIZATION SERIES CIRCLE *If Given Before Arrival*	Date Given	Date Given
DPT 1 2 3 4 5		
POLIO 1 2 3 4		
MMR 1 2 3		
VARICELLA 1 2		
Hip 1 2 3 4		
HepB 1 2 3		

IMMUNIZATION SERIES CIRCLE *If Given Before Arrival*	Date Given	Date Given
TD 1 2 3		
TD BOOSTER (WITHIN 10 YEARS)		
INFLUENZA		
ADULT VARICELLA 1 2		
PNEUMONIA		
OTHER		

ADDITIONAL T.B./HEPATITIS INFORMATION

TB CHEST X-RAY Ordered:_____COMPLETED_____ FINDINGS_____
DATE DATE

TB Medicines? **YES ❑ NO ❑ Pending ❑** IF YES, Date Started:_____

Hepatitis B: Number of household contacts: #_____ Number of contacts treated: #_____

Interpreter_____

OTHER REFERRALS: Dental: ❑ Child Health: ❑ Family Planning: ❑ Medicaid/RMA ❑
WIC: ❑ ER/Urgent Care ❑ Medical Follow-up ❑ Other:_____
Mammogram: ❑ Perinatal Care: ❑ Mental Health Screening: ❑

Name:_____ "A"Number:_____

HEALTH HISTORY

IN THE LAST YEAR:

✓CHECK ALL THAT APPLY

	FEVER		JAUNDICE
	COUGH		NIGHT SWEATS
	DIARRHEA		RASH
	HEADACHES		VOMITING
	HEMOPTYSIS		WEIGHT LOSS

ALLERGIES_____

MEDICINES_____

MEDICAL PROBLEMS_____

INJURIES/ACCIDENTS_____

SURGERY_____

RECENT ILLNESS IN FAMILY_____

FOR WOMEN	CHILDREN AGES 0-6 YEARS
LMP_____ FAMILY PLANNING YES ❑ NO ❑ # PREGNANCIES_____ Last PAP TEST_____ Date LIVE BIRTHS_____ Last BREAST EXAM_____ Date LIVING CHILDREN_____ PREGNANT? YES ❑ NO ❑	PLACE OF BIRTH:_____ PROBLEMS AT BIRTH:_____ CHILDHOOD DISEASES:_____ LEAD SCREENING DATE (6 - 72 months):_____

PHYSICAL EXAMINATION

Not Done: **NA** Normal: **N** Abnormal: **A**	**PERTINENT FINDINGS**
1. General Appearance_____	
2. Head _____	
3. Eyes _____	
4. Ears _____	
5. Nose _____	
6. Oral Cavity (Dental) _____	
7. Pharynx _____	
8. Neck _____	
9. Lymph Nodes _____	
10. Cardiovascular _____	
11. Chest_____ Lung_____ Breast_____	
12. Abdomen _____	
13. Skin _____	
14. Male Inguinal Hernia _____ Female-Pap Smear _____	
15. Neurological _____	
16. Musculoskeletal _____	

ASSESSMENT AND PLAN:

EXAMINER'S SIGNATURE ✓_____ DATE_____